Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____School Year:_____Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____Student age:_____Date of Birth:_____

Grade:_____Homeroom/Classroom:_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication:_____

Reason for medication:_____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school):_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other:_____

Physician's Signature_____Physician's Name:_____

Date_____Phone_____ Address:_____

♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦

Pursuant to KRS 158.832 to KRS 158.836 _____ school permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/ guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been **instructed** on self-administration of this medication: **to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY**

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:_____Date_____

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the _____School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date:_____Signature:_____Relationship:_____

Home phone:_____Work phone:_____Emergency phone:_____

Modeled after the American Academy of Pediatrics

Madison County Board of Education

Authorization/Parental Consent for Administering Over-the Counter Medication
(When no nurse is available at school)

Student's Last Name_____ First Name_____MI_____

Student Number_____ Grade_____ Date of Birth_____/ ____/ ____

Allergies_____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following over-the-medication (see below) for use when no nurse is available at the school site. I hereby acknowledge that I have read and understood the School Board Recommendations for distribution of medications to students. I hereby release _____ School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

X_____ (_____)_____ _____

Parent/Guardian Signature | Daytime Phone | Date

Over the counter medications can be given no more than 3 consecutive days without a physicians order. (09.2241.AP1)

Student Name: Last	First	MI	Age

Grade	Teacher

Reason student receiving medication		
Name of medication	Dosage	Date to DC
Possible reactions		
Form of medication ☐ Tablet ☐ Pill ☐ Capsule ☐ Liquid ☐ Inhalant	☐ Other	
Feedback required ☐ Yes ☐ No	How often	

SAMPLE MEDICATION ADMINISTRATION DAILY LOG

School Year: _____ Name of Student: _____

Date of Birth: _____ Sex: _____ Grade/Homeroom: _____

Name of School: _____

Name and Dosage of Medication: _____

Route _____ Frequency: _____ Times in School: _____

Health Care Provider Name/Number: _____

Emergency Contact Name/Number: _____

Directions: Initial with time of administration. A complete signature and intitals of each person administrating medications should be included below.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															

Initial (of person administering medication)	Signature	Initial (of person administering medication)	Signature

Codes

(A) Absent

(0) No show

(E) Early Dismissal

(W) Dosage withheld

(F) Field Trip

(X) No school

(N) No medication available

(S) Self-administered

Source: Texas School Health, The Texas Guide to School Health Programs

SAMPLE MEDICATION ADMINISTRATION DAILY LOG

Date	Explanation with Signature	Date	Explanation with Signature

Source: Texas School Health, The Texas Guide to School Health Programs

Madison County Board of Education

Medication Administration Incident Report

Name of school:_____ Date: Time:

Name of student:_____ Birth Date:

Name of person administering medication:_____

Name of medication and dosage:_____

Describe circumstances leading to error:_____

_____

_____

_____

Describe actions taken:_____

_____

_____

Persons notified of error: (include name and title)

School Nurse: (if applicable)_____

Principal:_____

Parent or guardian:_____

Physician: (if applicable)_____

Other:_____

Signature of person completing report:_____

Signature of Reviewer: _____
(School Nurse)

Follow-up information (if applicable)_____

_____

Madison County Board of Education

Refusal to Administer Medication

Date:_____

Dear Parent,

You have requested school personnel to administer medication to your child,

_____during school hours.
Name of Child

After reviewing the school medication policy, we cannot give this medication to your child for reason(s) checked below:

1. Medication received without written authorization.
2. Medication was **not sent** to school in the original container.
3. Medication prescribed twice daily can be administered before and after school hours.
4. Medication prescribed three times a day can be given before school after school and at bedtime.
5. Student has an elevated temperature which is_____ today.
6. Student has had medication every day for _____ days. We cannot continue to administer medication for longer than designated on bottle.
7. Complaints of the student include:_____

8. Other _____

Should your child's health care provider feel that your child needs this medication during school hours, medication will be given after receiving written request form from the prescribing physician or other authorized health provider.

Providing protection for students as well as our staff is of utmost importance as we endeavor to administer medication at school. You may talk to the nurse by calling the school.

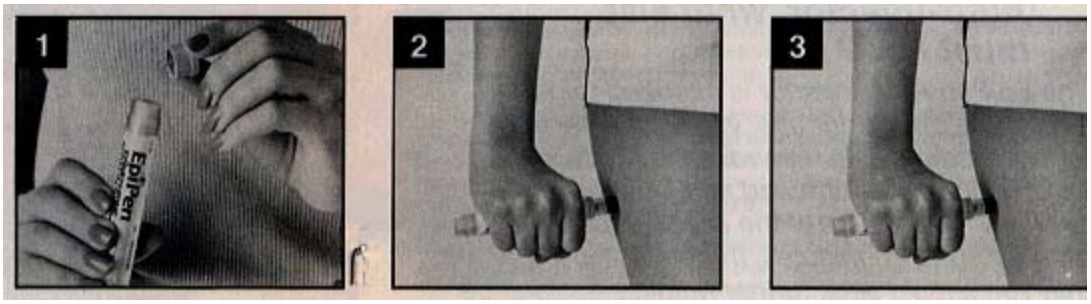
Thank you for your cooperation in this matter.

HOW TO USE EPIPEN ® AND EPIPEN JR. ®

1. **Pull of gray activations cap.**

2. **Hold black tip near outer thigh (always apply to thigh).**

3. **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen ®unit should then be removed and discarded. Massage the injection area for 10 seconds.**



Diabetes Emergency Response

Administration

CALL 911

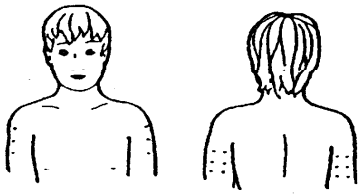
Glucagon Injection

- Use only when child is unconscious or having a seizure.
- Keep in a convenient, known place. Store in refrigerator during hot weather. Protect from freezing.
- Keep a 3cc syringe available or use the fluid filled syringe in the Lilly Emergency Kit.
- If you have the emergency kit, skip steps 1 and 2 below.

Insert 1/2 cc of air into fluid bottle (1cc won't fit).

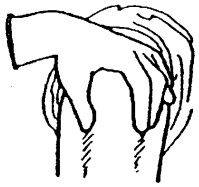
Draw out 1 cc of fluid from bottle.

Inject the 1cc of fluid into bottle with tablet. Mix.



Remove cap from syringe.

Grasp cleansed area of arm between thumb and forefinger with your nondominant hand, but do not squeeze skin/tissue.



Hold syringe between thumb and forefinger.

- Inject either deep into muscle (in front of leg or upper, outer arm) or into the subcutaneous fat (just as you would an insulin shot).
- Give sips of juice, sugar pop, or sugar in water initially as soon as he/she awakens. Honey may help to raise the blood sugar. After 10 minutes, encourage solid food (crackers and peanut butter or cheese sandwich, etc.)
- Notify diabetes care team of severe reaction prior to next insulin injection (so dose can be changed it needed). Complete recovery may take 1-2 hours.

Source: Madison County Board of Education, Kentucky

GLUCAGON TRAINING PROGRAM

Instructor:_____

1. **Written materials provided**
2. **Written materials discussed**
3. **Procedure demonstration**
4. **Return demonstration given**
5. **Opportunity for questions and answers**

I attended the GLUCAGON training program on and the above items were included in that program.

Name of Participant	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Source: Madison County School Health Program

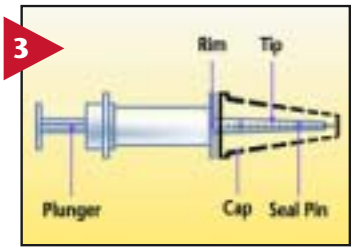
How to Administer

Diastat® (diazepam rectal gel)

Stop the seizure. Fast.

Put person on their side where they can't fall

Get medicine



Get syringe

Push up with thumb and pull to remove protective cover from syringe

Lubricate rectal tip with lubricating jelly

Turn person on side facing you

Bend upper leg forward to expose rectum

Separate buttocks to expose rectum

Gently insert syringe tip into rectum

Note: Rim should be snug against rectal opening.

SLOWLY COUNT OUT LOUD TO THREE...1...2...3

Slowly count to 3 while gently pushing plunger in until it stops

Slowly count to 3 before removing syringe from rectum

Slowly count to 3 while holding buttocks together to prevent leakage

ONCE DIASTAT® IS GIVEN

Keep person on side facing you, note time given and continue to observe

CALL FOR HELP IF ANY OF THE FOLLOWING OCCUR

- Seizure(s) continues 15 minutes after giving DIASTAT or per the doctor's instructions: _____
- Seizure behavior is different from other episodes.
- You are alarmed by the frequency or severity of the seizure(s).
- You are alarmed by the color or breathing of the person.
- The person is having unusual or serious problems.

Local Emergency Number: _____

(please be sure to note if your area has 911)

Doctor's Number: _____

Information for Emergency Squad: *Time DIASTAT given:* _____ *Dose:* _____

Guidelines on Medication Procedures
A Summary

The National Education Association, the American Federation of Teachers, the Council for Exceptional Children, and the National Association of School Nurses jointly published a document entitled *Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Health in the Educational Setting* in 1990. This same chart was brought forward into the 1997 publication cited at the bottom of the page. While these guidelines cover a wide range of activities and school employees, the general policy regarding medication may be summarized as follows:

School employees other than a registered nurse or a health assistant are prohibited from administering medication except in emergencies that require a single dose injection of epinephrine or medication inhalation for a life threatening condition. Even in these emergencies, other school employees may administer medication only if they have been properly trained and if a registered nurse or health assistant is unavailable.

The guidelines define "emergency" as "a serious situation that arises suddenly and threatens the life or welfare of a person: a crisis."

Guidelines for the Delineation of Roles and Responsibilities
For the Safe Delivery of Specialized Health Care In The Educational Setting*

	Procedure	Prescriber Order Required	Registered Nurse (RN)	Licensed Practical Nurse (LPN)	Certified Teaching Personnel	Related Services Personnel	Para-professionals[1]	Others[2]
4.0 Medications - Medications may be given by LPN's and Health Aides only where the Nurse Practice Act of the individual state allows such practice, and under the specific guidelines of that nurse practice act.								
	Oral	•	A/O	S/O	X	X	S/HA	X
4.2	Injection	•	A/O	S/O	X	X	X	X
4.3	Epi-Pen Allergy Kit	•	A/O	S/O	EM	EM	EM	EM
4.4	Inhalation	•	A/O	S/O	EM	EM	EM/HA	EM
4.5	Rectal	•	A/O	S/O	X	X	EM/HA	X
4.6	Bladder Installation	•	A/O	S/O	X	X	X	X
4.7	Eye/Ear Drops	•	A/O	S/O	X	X	S/HA	X

Definitions of Symbols

A	Qualified to perform task, not in conflict with professional standards	X	Should not perform
S	Qualified to perform task with RN supervision and in-service education	O	Person who should be designated to perform task
EM	In emergencies, if properly trained, and if designated professional is not available		

1. Paraprofessionals include teacher aides, health aides (HA), non- certified teaching personnel.
2. Others include secretaries, bus drivers, cafeteria workers, custodians

***DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSING PRACTICE ACT.**

Adapted from *The Medically Fragile Child in the School Setting* 2nd Ed. (1997). Appendix D: Guidance for Staff Roles in Providing Care, Washington DC: American Federation of Teachers

In Zaiger, D.S. (2000) School Nursing Practice, An Orientation Manual, Ch III, p. 17.

MEDICATION ADMINISTRATION TRAINING FOR SCHOOL PERSONNEL

Training Guidelines:

School personnel giving medication shall receive formal training and monitoring. Training will be provided by personnel such as, but not limited to registered nurses, physicians, pharmacists and/or dentist. Medical personnel should adhere to the practice act standards for their profession as governed by the appropriate licensing authority.

Purpose: to assist each student with medication administration in order to maintain optimal health and to enhance the educational experience.

Objectives: Upon completion of the medication administration training, the participant(s) will demonstrate and/or verbalize the following competencies:

1. Safely administer medication under the law KRS 156.501 and JCPS requirements
2. Know the five rights (5 R's) of medication administration
3. Proper authorization process for medication(s) to be given at school
4. Read medication label
5. Follow directions on medication label correctly
6. Proper storage of prescription and over-the counter medication
7. Appropriate and correct record keeping regarding medication and/or self-administered medication
8. Correct and accurate notations on the record if medications are not taken/given either by refusal, omission, etc.
9. Proper action to be taken if medication is not taken/given either by refusal, omission, etc.
10. Use of resources correctly-i.e. nurse, physician, poison control, emergency services when appropriate

Evaluation process

Objectives will be evaluated through either post-test or return demonstration(s), post-training monitoring, and annual training

DELEGATION OF HEALTH SERVICE(S) TO SCHOOL PERSONNEL

School Year: _____ Date: _____

Employee Printed Name_____

School: _____

I have been instructed on my school district's guidelines for:

Employee Initials	Health Services Nurse's Initials	
		Administration of medications on daily basis and field trips
		Administration of medication on field trips only
		Asthma and Mini-nebulizer treatments
		Diabetes and blood glucose monitoring
		Epi-pen
		G-tube feedings
		G-tube medication administration
		Seizure and Diastat
		Trachs and suctioning

I understand that I am to follow district guidelines as delegated by the School Nurse. Upon signing this, I consent to perform the health service(s) initialed above by the delegating School Nurse and myself, possess the training and skills, and have demonstrated competency to safely and effectively perform the health service(s).

_____ _____

Employee Signature Date

I have provided training to this individual on the health service(s) initialed above by the employee and myself in accordance with school district guidelines. She/he has demonstrated knowledge and understanding of this/these health service(s).

_____ _____

School Nurse Stamp/Signature Date

Source: Jefferson County Public Schools

MEDICATION ADMINISTRATION RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Perform with minimum verbal clues	Unable to perform
Oral Medication:			
Verbalizes & follows five (5) rights			
Able to read prescription label			
Check's Medication Authorization with prescription label			
Observes student taking (swallowing) medication			
Replace cap tightly or securely on medication bottle & locks up medication appropriately			
Documents on medication log sheet appropriately			
Calls student to office (if appropriate) in allotted time (30 minutes before or 30 minutes after)			
Topical (ointment) Medication:			
Verbalizes & follows five (5) rights			
Able to read prescription label			
Check's Medication Authorization with prescription label			
Washes hands and puts on gloves			
Applies medication to appropriate area			
Replaces cap tightly and locks up medication appropriately			
Removes gloves & washes hands			
Documents on medication log sheet appropriately			
Calls student to office (if appropriate) in allotted time (30 minutes before or 30 minutes after)			

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools

MEDICATION ADMINISTRATION RETURN DEMONSTRATION CHECKLIST

Eye drops or ointment			
Verbalizes & follows five (5) rights			
Able to read prescription label			
Check's Medication Authorization with prescription label			
Washes hands & puts on gloves			
Stabilizes head by having head titled back or by lying down			
Gently pulls lower lid away from eye to form "pocket"			
Places drop(s) into pocket area, allows drop to fall (doesn't touch bottle tip to eye or eyelid)			
Applies thin strip of ointment into "pocket" without touching eye or eyelid			
Has student close eye a few moments			
Wipes tip of bottle/tube with clean tissue			
Replace cap tightly or securely on medication bottle & locks up medication appropriately			
Removes gloves and washes hands			
Documents on medication log sheet appropriately			
Calls student to office (if appropriate) in allotted time (30 minutes before or 30 minutes after)			
Ear drops:			
Verbalizes & follows five (5) rights			
Able to read prescription label			
Check's Medication Authorization with prescription label			
Washes hands and puts on gloves			
Loosens lid on medication, squeezes rubber pump to fill dropper			
Stabilizes head by titling head back or by lying down			
Gently pulls ear appropriately			
Holds dropper without touching ear or inserting to far			
Has student lie still a few moments & and if applicable inserts moist cotton ball into ear			
Replaces cap tightly and locks up medication appropriately			
Removes gloves & washes hands			
Documents on medication log sheet appropriately			
Calls student to office (if appropriate) in allotted time (30 minutes before or 30 minutes after)			

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools

ASTHMA RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Inhaler			
Verbalizes & follows five (5) rights			
Able to read prescription label			
Check's primary care provider Asthma authorization for completion (especially primary care provider's signature) with prescription label			
Washes hands			
Checks that canister is firmly positioned in plastic holder			
Attaches spacer and uses it appropriately (if prescribed)			
Shakes inhaler thoroughly			
* Has student take a deep breath in and out			
* On next deep breath in observes student taking puff from inhaler			
* Observes student hold breath for 5-10 seconds after inhaler used			
* Observes student exhale slowly			
* Has student wait a few minutes before taking second puff			
Observes student follow above steps (*) with second puff			
Places medication back in medication box & locks up medication appropriately			
Washes hands			
Documents on medication log sheet appropriately			
(**) Calls student to office (if appropriate) in allotted time (30 minutes before or 30 minutes after)			
Peak Flow Meter			
Check's primary care provider Asthma authorization for completion (especially peak flow meter ranges/instructions and primary care providers signature)			
Washes hands & puts on gloves			
(*)Places pointer at base of number scale (0)			
(*) Have student hold meter, take a deep breath, place meter in mouth & close lips around mouth piece, blow out hard and fast			
Have student repeat step (*) two more times			
Record highest of three readings and follow primary care provides instructions based on reading (i.e. administer medication)			
Remove gloves and wash hands			
Calls student to office (as above (**))			

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools

ASTHMA RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Nebulizer			
Verbalizes & follows five (5) rights			
Able to read prescription label			
Check's primary care provider (especially primary care provider's signature) with prescription label			
Washes hands			
Gathers equipment (machine, tubing, nebulizer cup, mouthpiece or mask, medication, saline)			
Places nebulizer on firm, flat surface & plug it into electrical outlet			
Attaches the end of tubing to nebulizer air outlet			
Unscrews the top from the nebulizer cup, places medication & diluent into cup as prescribed			
Reattaches nebulizer cap tightly			
Attaches the connecting tubing to nebulizer cup outlet			
Has student sit in comfortable position			
Turn on power, observe for mist from mouthpiece or mask			
Give student mouthpiece to place between teeth & seal lips around it or place mask over nose & mouth, then observe student during treatment			
When mist has stopped, tap side of cup, if no further mist, treatment complete			
Turn of machine & remove mouthpiece or mask			
Unplug machine, & take apart equipment			
Rinse out & dry nebulizer cup, put equipment away			
Places medication back in medication box & locks up medication appropriately			
Washes hands			
Documents on medication log sheet appropriately			
Calls student to office (if appropriate) in allotted time (30 minutes before or 30 minutes after)			

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools

ASTHMA RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Peak Flow Meter			
Check's primary care provider Asthma authorization for completion (especially peak flow meter ranges/instructions and primary care providers signature)			
Washes hands & puts on gloves			
(*)Places pointer at base of number scale (0)			
(*) Have student hold meter, take a deep breath, place meter in mouth & close lips around mouth piece, blow out hard and fast			
Have student repeat step (*) two more times			
Record highest of three readings and follow primary care provides instructions based on reading (i.e. administer medication)			
Remove gloves and wash hands			
Calls student to office (as above (**))			

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools

DIABETES BLOOD GLUCOSE TESTING RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
General Diabetes knowledge			
Check's primary care provider Diabetes authorization for completion (especially primary care provider's signature)			
Verbalizes when glucose monitoring should be performed			
Verbalizes signs/symptoms of hypoglycemia & hyperglycemia			
Verbalizes Universal Precautions			
Blood glucose testing			
Gathers equipment (glucose testing meter, lancet device, strips, record sheet/book, gloves)			
Washes hands & puts on gloves			
Has student wash his/her own hands & dries them			
Inserts lancet into lancing device according to manufacturer's instruction, or observes student inserting lancet appropriately			
Inserts glucose strip into meter according to manufacturer's instructions, or observes student insert testing strip appropriately			
Warms fingers by rubbing, or have student warm fingers			
Puncture side of finger with lancing device, or observe student perform procedure appropriately			
Gently squeeze finger in downward motion to obtain an appropriate size drop of blood or observe student perform appropriately			
Place drop of blood on testing strip, or observe student perform step appropriately			
Apply band aid or have student hold pressure to puncture site briefly			
Verbalizes appropriate steps based on glucose testing results and primary care provider authorization (i.e. nothing needed, give glucose tablets, allow sugar-free drink & bathroom privileges)			
Removes test strip, turns of machine, disposes of lancet and strip appropriately			
Cleans test area			
Remove gloves & wash hands			
Document result on record sheet/book			

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools

DIABETES URINE KETONE TESTING RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Urine Ketone Testing			
Check's primary care provider Diabetes authorization for completion (especially primary care provider's signature)			
Verbalizes when ketone testing should be performed			
Verbalizes Universal Precautions			
Gathers equipment (ketone strips, cup for urine, timing device record sheet/book, gloves)			
Washes hands & puts on gloves			
Has student hold ketone strip in urine flow or student urinates in cup then dip ketone strip into urine			
Wait allotted time as directed on ketone test strip bottle			
Compare color of ketone test strip to chart on bottle			
Reads results & follows directions based on primary care provider's diabetes authorization			
Disposes of testing strip & urine appropriately			
Remove gloves & wash hands			
Documents results			

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools